Adalimumab (Humira®) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	RETAIL
IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here ☐	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐
• The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.pec.ha.osd.mil/PA_Criteria_and_forms.htm. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: Adalimumab (Humira®)

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Member # _____ Phone #: _____

Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **Is this a continuation of therapy with adalimumab?**	☐ Yes Coverage approved, limited to a quantity not to exceed 6 syringes (3 packs of 2 syringes) per 6 weeks.	☐ No Please proceed to Question 2
2. **Is the patient at least 18 years of age?**	☐ Yes Please proceed to Question 3	☐ No Coverage not approved
3. **Is adalimumab being prescribed for the treatment of moderately to severely active rheumatoid arthritis?**	☐ Yes Please proceed to Question 5	☐ No Please proceed to Question 4
4. **Is adalimumab being prescribed for the treatment of active arthritis in patients with psoriatic arthritis?**	☐ Yes Please proceed to Question 5	☐ No Coverage not approved
5. **Will the patient be receiving anakinra (Kineret®), etanercept (Enbrel®) or infliximab (Remicade®) in combination with adalimumab?**	☐ Yes Coverage not approved	☐ No Coverage approved, limited to a quantity not to exceed 6 syringes (3 packs of 2 syringes) per 6 weeks.

Step 3 **I certify the above is correct and accurate to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

Latest revision: Nov 2005